

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07087

181

### 1. PLACE OF DEATH:

County Harford  
City or town Harwood Grove Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Harford  
City or town Harwood Grove Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.  
(If rural, give LOCATION) no  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Lotta C. Adams

### 3. (b) Social Security Number

no

4. Sex Female 5. Color of race White 6. (b) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Joseph E. Adams

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1887

8. AGE: Years 82 Months 6 Days 24 If less than one day hrs. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual occupation Housework

11. Industry or business at home

12. Name John Crawford

13. Birthplace Harford Co., Md.

14. Maiden name Mary J. McCann

15. Birthplace Harford Co., Md.

16. Informant Mrs. Emma Briner

Address Harwood Grove Rural

17. Burial (Burial, cremation, or removal, which?) Burial Date thereof Aug. 24, 1947 (month) (day) (year)

Cemetery or crematory Grubbs Cem.

Location Harford Co., Md.

18. Funeral director H. S. Bailey

Address Arlington, Md.

19. Aug 20 47 Betha B. Knight Registrar

(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1943 to Aug 17 1947

and that I last saw him alive on Aug 15 1947

Immediate cause of death Cerebral, Chronic glomerular nephritis

Due to Ante-natal & post-natal disease

Other conditions

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ralph H. H. H.

Address Churchville Md

Date signed Aug 19 1947

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 15 1947  
BUREAU V S

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07089

181

### 1. PLACE OF DEATH:

County Harford

City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford

City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)

Street No. South Chapel Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Santa Banks

### 3. (b) Social Security Number

4. Sex

male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

unmarried

6. (b) Name of husband or wife Jennie Banks

6. (c) If alive, give age ? years

7. Birth date of

deceased (mo., day, yr.) Aug. 28, 1947 1880

8. AGE:

Years

Months

Days

If less than one day

67

8

28

hrs.

min.

9. Birthplace Aberdeen Harford Co. Maryland  
(Town, county, and state)

10. Usual occupation Paul Rode Saborer

11. Industry or business

FATHER

12. Name

Santa Banks

MOTHER

13. Birthplace

Aberdeen Harf. Co. Md.

14. Maiden name

Jennie Matthews

15. Birthplace

Aberdeen, Md.

16. Informant Mrs. Mary Banks

Address

Aberdeen, Md. 31

17. Personal Burial  
(Burial, cremation, or removal. Which?)

Date thereof Aug. 28, 1947  
(Month) (day) (year)

Cemetery or crematory

Int. Colvany

Location

Aberdeen

18. Funeral director Henry Tarring & Sons

Address

Aberdeen, Md.

19. Aug 30 19 47

(Date rec'd by registrar)

Nellie H. Riley

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 19 47 at 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 27 19 47, to Aug 28 19 47

and that I last saw him alive on Aug 27 19 47

Immediate cause of death

Chronic Congestive Cardiac failure

DURATION

Due to

Arteriosclerotic Cardio-Vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Ramsey, M.D.

M. D. on

Address Aberdeen, Md. Date signed 8/29/47

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07090

Reg. Diat. No. 182

## 1. PLACE OF DEATH:

County Hartford  
 City or town Near Bel Air, Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 38 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md County Hartford  
 City or town Bel Air Md (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

Thomas Roy Brookus

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced M  
 6.(b) Name of husband or wife Hannah M Brookus  
 6.(c) If alive, give age years  
 7. Birth date of deceased (mo., day, yr.) May 22-1883  
 8. AGE: Years 64 Months Days If less than one day  
 hrs. min.

9. Birthplace Hartford Co., Md  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business

FATHER 12. Name Thomas Jay Brookus  
 13. Birthplace Md  
 MOTHER 14. Maiden name Margaret Harry  
 15. Birthplace Md

16. Informant Mrs Hannah M Brookus  
 Address Bel Air, Md

17. Burial Date thereof Aug 18-1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Mary's  
 Location Emmorton, Md

18. Funeral director Dean T Foster  
 Address Bel Air, Md

19. 8/17 19 47 Priscilla Lowwood  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 47 at 6 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Aug 15 19 47  
 and that I last saw him alive on Aug 15 19 47

Immediate cause of death Cerebral Hemorrhage DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

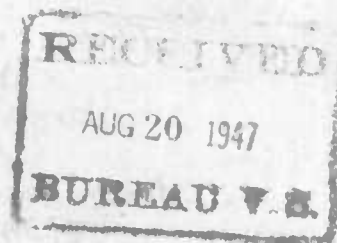
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. D. or other

Address Bel Air, Md Date signed 8/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07091

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HarfordCity or town Home de Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Home de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. Sumner Lane  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Alexander Brown

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

about 60 yrs - 1887

8. AGE: Years Months Days It less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address Wm. McComasHome de Grace17. Burial Date thereof 8/16/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. JamesLocation Home de Grace18. Funeral director Pennington & SonAddress Home de Grace, Md.19. 8-16 19 47 A. L. Lewis M.D.

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 47, at 10:45 A.M.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

August 15 19 47 to same 19 47and that I last saw him alive on August 15 19 47

Immediate cause of death

Cerebral haemorrhage

DURATION

3 hoursDue to Arteriosclerosis

Due to

Due to

Other conditions Pulmonary tuberculosis,far advanced

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. V. Redman, M.D.Address Wetzel, Ind.Date signed 8/16/47

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AUG 18 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

07092

## 1. PLACE OF DEATH:

County HarfordCity or town Bel Air Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah F. Caudill

## 3. (b) Social Security Number

— No

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

R. F. Caudill

7. Birth date of deceased (mo., day, yr.)

June 11, 1875

6. (c) If alive, give age

68 years

8. AGE:

Years

Months

Days

If less than one day

73 2 3 hrs. min.

9. Birthplace

Wilkes Co. M.C.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

at home

12. Name

Elizabeth Mc Bride

13. Birthplace

Wilkes Co M.C.

14. Maiden name

Almedia Harris

15. Birthplace

Wilkes Co., M.C.

16. Informant

Mr. R. F. Caudill

Address

Bel Air, Md. Rural

17. Burial

Aug 16, 1947  
(Burial, cremation, or removal, which)

Cemetery or crematory

Baptist Church

Location

Harford Co. Md.

18. Funeral director

H. A. Bailey

Address

Charlottesville, Md.Aug 15 47  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD County Harford

City or town

Rural - Bel Air  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Thomas' Run  
(If rural, give LOCATION)

2. (a) If veteran, name war

No

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1947 at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 8 1947 to Aug 13 1947and that I last saw her alive on Aug 13 1947

Immediate cause of death

Coronary ThrombosisLOBAR (Hypostatic) pneumonia

DURATION

5 da.3 da.

Due to

Due to

Other conditions

Ch. Cholecystitis withstones  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Willard P. Hudson  
M. D. or otherAddress Forest Hill Md. Date signed 8/14/47



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SEP 30 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07093

Reg. Dist. No. 189

## 1. PLACE OF DEATH:

County... HarfordCity or town... Whiteford Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

George C. Cautler

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

May 2 - 1931

8. AGE:

Years

Months

Days

If less than one day

16220

hrs.

min.

9. Birthplace

Delta, York Co. Pa.  
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

Raymond Cautler

13. Birthplace

Harford Co. Md.

MOTHER

14. Maiden name

Nettie Mastagert

15. Birthplace

Scotland

16. Informant

Raymond Cautler

Address

Delta, Pa.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug. 16, 1947  
(month) (day) (year)

Cemetery or crematory

State Ridge cemetery

Location

Delta, Pa.

18. Funeral director

Hubert P. Harkine

Address

Delta, Pa.

19. August 14 47

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Penn.

County

York

City or town

Delta  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

August 12 1947 at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... 19... 19...

and that I last saw him... alive on... 19...

Immediate cause of death

Drowning.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accident Date of... 8/12/47Where did injury occur? Flintville Harford Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Bobcat Creek BridgeMeans of injury Drowning. Injured at work?

23. SIGNATURE

J. H. Ramsey, M.D.  
Dep. Medical Examiner M. D. or otherAddress... Abertown, Md. Date signed 8/12/47

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07094

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Navarre Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 3 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD. County Harford  
 City or town Navarre Grace, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 629 No. Stokes St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Rose Knox Clayman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Alfred Clayman  
 8.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 21, 1881  
 8. AGE: Years 65 Months 10 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Penn.  
 (Town, county, and state)  
 10. Usual occupation Carroll's Laundry

11. Industry or business Thomas Knox  
 12. Name Phila. Penn.  
 13. Birthplace Frances Wilding  
 14. Maiden name Penn.  
 15. Birthplace

16. Informant Mr. Alonzo O. Suitor  
 Address 629 No. Stokes St.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 16 1947  
 (month) (day) (year)  
 Cemetery or crematory Angel Hill  
 Location Navarre Grace, Md.

19. Funeral director R. Madison Mitchell  
 Address Navarre Grace Md.

19. Aug. 15 1947 A. L. Lewis m  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1947 at 2 A M  
 21. CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1947 to Aug 13 1947  
 and that I last saw him alive on Aug 13 1947

Immediate cause of death Hypertensive Heart Disease with Congestive Heart Failure  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Daniel D. Dolan, M.D.  
 M. D. or other \_\_\_\_\_  
 Address Navarre Grace Date signed 14 Aug 47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1947

BUREAU 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07095

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
 City or town Taber de Grace  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County YorkCity or town Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mr. Levi L. Cooper

## 3. (b) Social Security Number

## 4. Sex

MALE

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

WIDOWED

## 6. (b) Name of husband or wife

CATHERINE DONANCOOPER

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

March 22 - 1890

## 8. AGE:

Years

Months

Days

If less than one day

56410

hrs.

min.

## 9. Birthplace

Harford Co. Md.

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

MOTHER FATHER

## 12. Name

Sidney Cooper

## 13. Birthplace

York Co.

## 14. Maiden name

Mary Stewart

## 15. Birthplace

York Co.

## 16. Informant

Stephen Cooper

## Address

Delta York Co. Penna.

## 17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

8/4/47

(month) (day) (year)

## Cemetery or crematory

Mt. Nebo

## Location

York Co. Penna.

## 18. Funeral director

Hubert P. Harkins

## Address

Delta, Penna.

## 19.

(Date rec'd by registrar)

19 47H. L. Lewis m. d.

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

August 1<sup>st</sup> 1947

## 21. I CERTIFY that death occurred on the data above stated; that I attended deceased from

7-22-47 19 8-1-47 19and that I last saw him alive on 7-31-47 19

## Immediate cause of death

Pulmonary embolism

## DURATION

## Due to

Coronary heart failure

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

none

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

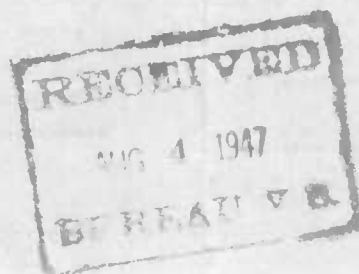
John F. Noznera M.D.

M. D. or other

## Address

Harford Memorial Hosp.Date signed 8-1-47





PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07096  
189

## 1. PLACE OF DEATH:

County Hartford  
 City or town Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 yrs  
 Hospital, institution, or street address where death occurred:  
129 Osborn Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Hartford  
 City or town Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 129 Osborn Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

C. 1st Lt. H.

## 3. (a) FULL NAME

Flora Scarborough Crumlish

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Joseph Crumlish  
 7. Birth date of deceased (mo., day, yr.) October 16, 1876  
 8. AGE: Years 70 Months 9 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name John M. Scarborough13. Birthplace Hartford Co. Md.14. Maiden name Viola Malone15. Birthplace Pennsylvania16. Informant Mrs. Viola CrumlishAddress 129 Osborn Rd. Aberdeen17. Burial Date thereof Aug 17, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium State Ridge, Delta, Pa.Location Delta, Pa.18. Funeral director Henry Tarkenton & SonsAddress Aberdeen, Md.19. Aug. 16th 19 47  
(Date rec'd by registrar)Registrar Nellie H. Libby

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 19 47 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 7 19 47 to Aug. 15 19 47  
 and that I last saw him alive on Aug. 15 19 47

Immediate cause of death  
Pulmonary Embolism  
Coronary Insufficiency  
Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

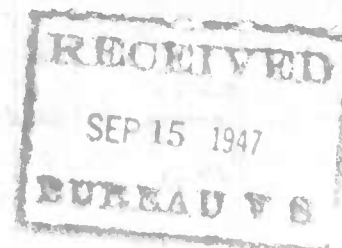
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. D. Ramsey M. D. or otherAddress Aberdeen Md Date signed 8/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

07097

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Home de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? all his life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Home de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Eric Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Thomas Hennissou

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

\_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

July 27, 1874

8. AGE:

Years 73 Months 4 Days 14

9. Birthplace

Perryman, Md.  
(Town, county, and state)

10. Usual occupation

Railroading (Retired)

11. Industry or business

John Carver Hennissou

12. Name

Perryman, Md.

13. Birthplace

Hester, Selden

14. Maiden name

Perryman, Md.

15. Birthplace

Mr. Edward Hennissou

Address 576 Lewis Street

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 8 14 47

(month) (day) (year)

Cemetery or crematory

Location

Funeral director

Address

19. Aug 13 1947

(Date rec'd by registrar)

1947

G. L. Lewis m. s.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1947 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 9 1947 to Aug 10 1947

and that I last saw him alive on Aug 10 1947

Immediate cause of death

Cerebral hemorrhage

Due to

arteriosclerosis -

Due to

essential hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

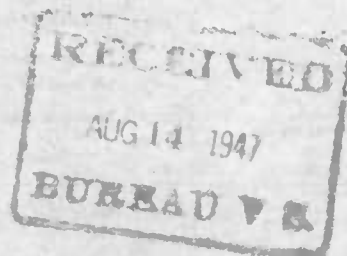
Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07098

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County Harford  
 City or town Rural Harford Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Harford  
 City or town Rural Harford Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war.

## 3. (a) FULL NAME

Fredricka Evans

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife John F. Evans

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 8, 1859

8. AGE: Years 88 Months 3 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

8. Birthplace Harford Co. Md.  
(Name, county, and state)10. Usual occupation Retired 12 yr.11. Industry or business House Duties12. Name John W. Carroll13. Birthplace Md.14. Maiden name Sarah Katz15. Birthplace Pruss.16. Informant Mrs. Jessie Evans TolsonAddress Harford Grace H.D. #117. Burial (Burial, cremation, or removal, which?) Aug. 27, 1947Cemetery or crematory Wesleyan ChapelLocation Harford Co. Md.19. Funeral director H. Madison MitchellAddress Harford Grace Md.20. Date rec'd by registrar Aug. 26 1947Registrar Beth B. Knight

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1947, at 5-15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3 1947 to Aug. 24 1947and that I last saw him/her alive on Aug. 24 1947Immediate cause of death CachexiaDue to Cardioma of Liver

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

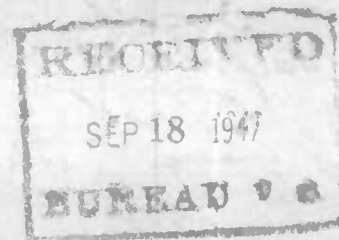
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE [Signature] M.D. or other \_\_\_\_\_Address [Signature] Date signed 8/26-47





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

07099

### 1. PLACE OF DEATH:

County Harford  
City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 yrs.  
Hospital, institution, or street address where death occurred:  
40 Monroe St.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 40 Monroe St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary L. Flagg

### 3. (b) Social Security Number

215-24-8464

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widow, or divorced Married

6.(b) Name of husband or wife Gus Flagg

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1901

8. AGE: Years 44 Months 10 Days  It less than one day  hra.  min.

9. Birthplace Jeffersonville, Tripp Co., Ga.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name Charlie Moore  
13. Birthplace Jeffersonville, Ga.  
14. Maiden name Katie Arbrey  
15. Birthplace Jeffersonville, Ga.

16. Informant Miss Jennie Smith  
Address 14 Lippincott St. Aberdeen

17. Removal (Burial, cremation, or removal. Which?) Removal Date thereof Aug. 16, 1947  
(month) (day) (year)

Cemetery or crematory Jeffersonville  
Location Jeffersonville, Ga.

18. Funeral director Henry Larringer & Sons  
Address Aberdeen, Md.

19. 8/15/47 A. W. Hedrick  
(Date read by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1947 12:09 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1, 1947 to Aug. 14, 1947  
and that I last saw him alive on Aug. 17, 1947

Immediate cause of death Pulmonary embolism  
DURATION 3 mo.

Due to Acute myocarditis

Due to

Other conditions Cholera  
(Include pregnancy within 3 months of death)

Major findings of operations  Date of op.

Antopsy results   
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Maana of injury  Injured at work?

23. SIGNATURE Charles J. Kelly, M.D.  
Address Harford County, Md. Date signed 8/15/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

07088

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred:

St. Francis VillaHow long in hospital or institution? 8 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)Street No. Commerce & Market  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sister Mary Charldine (Francis C Austin)

## 3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife

6. (c) If alive, give ago years

7. Birth date of deceased (mo., day, yr.) Jan. 31 - 18688. AGE: Years 79 Months 8 Days 19 If less than one day

hrs. min.

9. Birthplace London, England  
(Town, county, and state)10. Usual occupation Nurse

11. Industry or business

12. Name Wm. Francis Austin13. Birthplace Australia14. Maiden name Elizabeth G. White15. Birthplace Birmingham, England16. Informant Thos. P. ParnasAddress Commerce & Market, Harford17. Burial Date thereof 8/23/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy RedeemerLocation Baltimore, Md.18. Funeral director Pennington & SonAddress Harford, Md.19. Aug. 21 19 47 A. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 19 47, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 40 19 40, to Aug. 19 19 47and that I last saw him alive on Aug. 19 19 47Immediate cause of death Chronic MyocarditisDue to Coronary Thrombosis

Due to

Other conditions Cardiac Failure

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

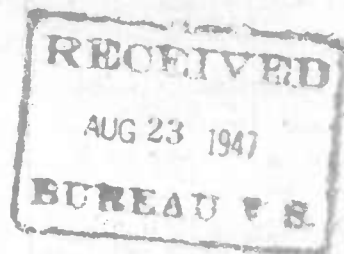
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.Address Harford, Md. Date signed 8/24/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160C

07100

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long on hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harre de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Baby Girl Gilbert

## 3.(b) Social Security Number

## 4. Sex

Female

## 5. Color or race

Caucas

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

July 27, 1947

## 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

27

hrs.

min.

## 9. Birthplace

Harre de Grace Md  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## 12. Name

William W. Becker

## 13. Birthplace

Abingdon Md

## 14. Maiden name

Irene Gilbert

## 15. Birthplace

Marysville Md

## 16. Informant

Irene Gilbert

## Address

Marysville Md

## 17.

Burial

## Date thereof

Aug. 26, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Marysville Baptist

## Location

Marysville Md

## 18. Funeral director

Harold E. McCombs

## Address

Abingdon Md

## 19.

Aug. 29-47  
(Date rec'd by registrar)G. L. Lewis M.D.  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

August 24, 47 5:40 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 27 1947 to Aug. 24 1947  
and that I last saw him/her alive on Aug. 24 1947

## Immediate cause of death

Prematurity  
nutritional dystrophy

## DURATION

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

John F. Noguera MD

M. D. or other

## Address

Harford & Mem HarpDate signed 8/24/47

RECEIVED  
SEP 1 1947  
BUREAU V.E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07101

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County... Harpford  
 City or town... Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
Bush Chapel Rd. Aberdeen, Md.  
 How long in hospital or institution? none

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Harpford  
 City or town... Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Bush Chapel Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Isaac Franklin Giles

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Mrs Annie E. Giles

7. Birth date of deceased (mo., day, yr.) July 7, 1878 6.(c) If alive, give age 60 years

8. AGE: Years 69 Months 1 Days 14 If less than one day  
 ....hrs. ....min.

9. Birthplace Aberdeen, Md.  
 (Town, county, and state)

10. Usual occupation Butcher

11. Industry or business

12. Name Alfred Giles

13. Birthplace Berryman, Md.

14. Maiden name Sarah J. Giles

15. Birthplace Maryland

16. Informant Mrs Annie E. Giles

Address Aberdeen, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30-47  
 (month) (day) (year)

Cemetery or crematory Mt. Calvary Church

Location Aberdeen, Md.

18. Funeral director Henry Tarrington

Address Aberdeen, Maryland

19. Aug 28 47 Nellie H. Lilly  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 19 47 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 19 47 to Aug 26 19 47  
 and that I last saw him alive on August 26 19 47

Immediate cause of death ruptured heart  
failure

Due to hypertension +  
atherosclerosis

Due to poisoned

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Aubrey V. Gould, M.D.  
200 N Union Ave M. D. or other  
 Address Aberdeen signed 8/26/47

RECEIVED

SEP 2 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07102

185-

## 1. PLACE OF DEATH:

County HarfordCity or town Harford de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harford de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 247 Wilcox  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Baby Boy Grace

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Aug 26 1947 - 3 46 AM

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

8 hrs. 39 min.

9. Birthplace

Harford de Grace  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name

Claude H. Grace

13. Birthplace

Mass. Ruth Town

14. Maiden name

15. Birthplace

Manhattan N. Y.

16. Informant

Claude H. Grace (Father)

Address

247 Wilcox St. Harford de Grace

17.

(Burial, cremation, or removal. Which?)

Date thereof

8/28/47  
(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harford de Grace

18. Funeral director

Hamington & Son

Address

Harford de Grace, Md.

19.

(Date rec'd by registrar)

Aug. 29 19 47A. L. Lewis m. d.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 27 1947 at 12 30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug 26 1947 to Aug 27 1947and that I last saw him alive on Aug 27 1947

Immediate cause of death

Anoxia of central origin

Due to

Prematurity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera m.d.

M. D. or other

Address

Harford Mem HospDate signed 8/27/47

RECEIVED  
SEP 1 1947  
BUREAU F B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

07103

## 1. PLACE OF DEATH:

County Harford  
 City or town Harford de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Harford de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 701 N. Washington  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Mr. Richard Graham

## 3. (b) Social Security Number

-

4. Sex M 5. Color or race W. 6. (a) Single ☒ married ☐ widowed ☐ or divorced ☐  
 6. (b) Name of husband or wife Lida Allen Graham  
 6. (c) If alive, give age 58 years  
 7. Birth date of deceased (mo., day, yr.) Nov. 2, 1888

8. AGE: Year 58 Months 8 Days 29 If less than one day  
 hrs. min.

9. Birthplace Wilmington Del.  
 (Town, county, and state)  
 10. Usual occupation Retired Salesman

11. Industry or business .....

12. Name Wm. Graham

13. Birthplace Ireland

14. Maiden name Barth Peoples

15. Birthplace Ireland

16. Informant Mrs. Lida A. Graham  
 Address 701 N. Wash. St. Harford de Grace

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 8/4/47  
 (month) (day) (year)  
 Cemetery or crematory Bellevue Brook

Location Wilmington Del.

18. Funeral director Funeral Home  
 Address Harford de Grace

19. Aug. 4 19 47 G. L. Lewis Registrar  
 (Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 1<sup>st</sup> 47 19 47 at 3<sup>30</sup> P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-24-47 19 47 to 8-1-47 19 47  
 and that I last saw him alive on 8-1-47 19 47

Immediate cause of death Circulatory collapse

Due to Congestive heart failure

Due to .....

Other conditions Liver cirrhosis

(Include pregnancy within 3 months of death)

Major findings of operations .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:  
 Accident, suicide, or homicide .....

Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE John F. Voguer M.D. or other  
 Address Harford Mem Hosp Date signed 8-2-47

RECEIVED  
AUG 5 1947  
BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town Harre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 509 Chen  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Baby Girl Horton

## 3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8/5/47

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1 and 6 hrs.

9. Birthplace

Harre de Grace  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER

12. Name

Wm. J. Horton

13. Birthplace

Harre de Grace

14. Maiden name

Quirk Ryle

15. Birthplace

Calora, Cal G. Md.

16. Informant

Wm. J. Horton

Address

509 Chen17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

8/7/47

(month) (day) (year)

Cemetery or crematory

Angel Hill

Location

Harre de Grace

18. Funeral director

Burroughs & Son

Address

Harre de Grace19. Aug. 7

(Date read by registrar)

19 47A. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug. 6<sup>th</sup>19 47

at

7-25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Aug. 5<sup>th</sup> 19 47, to Aug. 6<sup>th</sup> 19 47

and that I last saw him alive on

Aug. 6<sup>th</sup> 19 47

Immediate cause of death

Prematurity

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John F. Noguera MD

M. D. or other

Address

Harford New HospitalDate signed 8/8/47

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AUG 11 1947  
BUREAU V A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HarfordCity or town Hane de Grace  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? about 17 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County HarfordCity or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)Street No. 20 New Country Rd

(If rural, give LOCATION)

2. (a) If veteran, name war none

## 3. (a) FULL NAME

W. Oliver Hughes, Jr

## 3. (b) Social Security Number

## 4. Sex

M.

## 5. Color or race

W.6. (a) Single ☐ married ☒ widowed ☐ or divorced ☐

## 6. (b) Name of husband or wife

Belle Hunter

## 7. Birth date of

deceased (mo., day, yr.)

April 11, 1883

## 8. AGE:

Years

Months

Days

If less than one day

644

hrs.

min.

## 9. Birthplace

Rock Run Harford Co. Md  
(Town, county, and state)

## 10. Usual occupation

Mgr. Harford Dispensary

## 11. Industry or business

Liquor Store

## FATHER

12. Name W. Oliver Hughes, Sr.13. Birthplace Rock Run Harford Co.

## MOTHER

14. Maiden name Estelle Morgan15. Birthplace Aberdeen Harford Co.16. Informant Mr. P. Leslie HughesAddress Aberdeen Md P. O. D.17. Burial Date thereof Aug. 14, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory GraveLocation Aberdeen Md18. Funeral director Henry Tarrington & SonsAddress Aberdeen Md19. Aug. 13 19 47 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11<sup>th</sup> 19 47 at 6<sup>15</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 11<sup>th</sup> - 19 47 to same 19and that I last saw him alive on Aug. 11<sup>th</sup> & 7 19Immediate cause of death Cerebral vascular accident

DURATION

Due to Hypertensive cardiovasculardisease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John F. Noguera MD

M. D. or other

Address Harford Mem Hospital Date signed 8/11/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 18 1947

BUREAU V B

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

169

67106

Reg. Dist. No. 180

### 1. PLACE OF DEATH:

County Harford  
 City or town Edgewood R.D. (Van Bitter)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? instant death  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Edgewood R.D. (Van Bitter)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.

### 3. (a) FULL NAME

James Elloise Lee

### 3. (b) Social Security Number

21807 0878

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mary Ruth Lee

7. Birth date of deceased (mo., day, yr.) Dec 23, 1919 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 27 Months 7 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Abingdon Maryland  
 (Town, county, and state)

10. Usual occupation Tramman Penn R.R.

11. Industry or business

12. Name Edward Lee

13. Birthplace Abingdon Md

14. Maiden name Bertha E. Butler

15. Birthplace Abingdon Md

16. Informant Edward Lee

Address Abingdon Md

17. Burial Date thereof Aug 13, 1947  
 (Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory John Wesley

Location Abingdon Maryland

18. Funeral director Howard R. McConner

Address Abingdon Md

19. Aug 11 19 47 Man M. Moulsdale  
 (Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 47 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Fracture spine DURATION Instant

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Compound fracture  
box femoral  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/11/47

Where did injury occur? Edgewood Harford (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) R.R. tracks

Means of injury Hit by train Injured at work? no

23. SIGNATURE Donald C. Palmer M.D.  
Attending Physician Harford County M. D. or other

Address Bethesda Md Date signed 8/9/47

MARGIN RESERVED FOR BINDING

(I)

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 15 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County... HARFORDCity or town... ABERDEEN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Hours, 45 Minutes

Hospital, institution, or street address where death occurred:

STATION HOSPITAL, ABERDEEN PRGR, MD.How long in hospital or institution? 2 Hours, 45 Minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... BALTIMORECity or town... BALTIMORE 25

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4004 CLEAT STREET, BROOKLYN

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

JOSEPH M. MEAGHER

## 3. (b) Social Security Number

NONE

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) SEPT. 8 - 1944

8. AGE: Years Months Days If less than one day

2 11 7 ..... hrs. .... min.

9. Birthplace.....

CAMBRIDGE MASS.

(Town, county, and state)

10. Usual occupation.....

CHILD

11. Industry or business.....

CHILD

12. Name.....

HERBERT J MEACHER

13. Birthplace.....

CANADA.

14. Maiden name.....

MARY T. STEWART

15. Birthplace.....

PA.

16. Informant.....

HERBERT J MEACHER

Address.....

4004 CLEAT ST. BROOKLYN

17. (Burial, cremation, or removal, Which?) Date thereof.....

BURIAL Aug 19-47

(month) (day) (year)

Cemetery or crematory.....

HOLY CROSS CEM

Location.....

H. A. Co

18. Funeral director.....

Bernard C. Harker

Address.....

121 E. WEST ST

19. (Date rec'd by registrar).....

Aug 18 19 47

Registrar.....

A.W. Fisher

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

AUGUST 15 19 47 at 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

AUGUST 15 19 47 to AUGUST 15 19 47

and that I last saw him alive on.....

AUGUST 15 19 47

Immediate cause of death.....

Cardiac -  
respiratory failure

DURATION

12 hrs

Due to.....

Dehydration acidosis66+

Due to.....

(Final diagnosis)  
pending completion of post  
mortem - see:114 & 1

Other conditions.....

Autopsy results: Pneumonia interstitial.

(Include pregnancy within 3 months of death) cause undetermined.

Major findings of operation.....

Hyperplasia, generalized, thymus and  
lymphatic tissue. (115) 47 a.s.

Date of op.....

Autopsy results.....

Gross - neg; lesions to be done

PHYSICIAN: Please underline the cause which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....

Edward C. Kuman M.D.

M. D. or other

Address.....

No. Hosp. APQ Md.

Date signed.....

16 Aug 47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

67108

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County HarfordCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:

Harford Memorial Hosp.How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Phoenixville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Broad  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

George Morency

## 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

Aug. 27, 1895

8. AGE:

Years

Months

Days

If less than one day

511119

hrs.

min.

9. Birthplace

Canada  
(Town, county, and state)

10. Usual occupation

Painter

11. Industry or business

FATHER

12. Name

Geo. Morency

13. Birthplace

Canada

MOTHER

14. Maiden name

Mary Daborie

15. Birthplace

Canada

16. Informant

Donald Morency

Address

Phoenixville, Md.

17. Burial

(Burial, cremation, or removal, which)

Date thereof

8/18/47  
(month) (day) (year)

Cemetery or crematory

St. Francis

Location

Waterville, Maine

18. Funeral director

Pennington & Son

Address

Harford, Md.

19. Date rec'd by registrar

Aug. 1519 47

A. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Aug 1947, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7 Aug 1947 to 15 Aug 1947and that I last saw him alive on 15 Aug 1947Immediate cause of death Cerebral Hemorrhage② Saddle Thrombus - AortaDue to BifurcationDue to Generalized ArteriosclerosisOther conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Sadouny M.D.Address Phoenixville, Md.Date signed 15 Aug 47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

*Handwritten signature*

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AUG 18 1947  
BUREAU 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07109

180

## 1. PLACE OF DEATH:

County Harford  
 City or town Abingdon  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Abingdon  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edward Alonzo Mouldsdale

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Christine Mouldsdale6.(c) If alive, give age 65 years7. Birth date of deceased (mo., day, yr.) Jan 5, 1880

8. AGE: Years 67 Months 7 Days - It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Abingdon, Harford Co., Md.  
 (Town, county, and state)

10. Usual occupation Carpenter

## 11. Industry or business

12. Name Joseph Mouldsdale13. Birthplace Maryland14. Maiden name Jane Keithley15. Birthplace Maryland16. Informant Mrs. Christine MouldsdaleAddress Abingdon Maryland17. Burial (Burial, cremation, or removal. Which?) Buried Date thereof Aug 9, 1947Cemetery or crematory CokesburyLocation Abingdon Md18. Funeral director Howard K. McCormackAddress Abingdon Maryland19. Aug 9 1947 Edward Mouldsdale

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947 at 9:52 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1945 to Aug 5 1947and that I last saw him alive on Aug 5 1947Immediate cause of death Carcinoma of rectum

DURATION

3 yrs?

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations Cs rectum with metastasisDate of op. Dec 1945

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Jed O Hodous, MD

M. D. or other

Address Edgewood MdDate signed Aug 5, 1947

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AUG 13 1947  
BUREAU 7 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

07110

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County Harford  
City or town Rural Harreds Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford  
City or town Rural Harreds Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. Chapel Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Louise Rutherford

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age — years  
7. Birth date of deceased (mo., day, yr.) June 1, 19478. AGE: Years 2 Months 25 Days — If less than one day — hrs. — min.9. Birthplace Harreds Grace, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Curtis Summers13. Birthplace Md.14. Maiden name Nancy Rutherford15. Birthplace Md.16. Informant Miss Nancy RutherfordAddress Harreds Grace, Md. R.D.17. Burial Date thereof Aug 27 1947  
(Burial, cremation, or removal. Which?) (month/day/year)Cemetery or crematory Angel's HillLocation Harreds Grace, Md.18. Funeral director R. Madison MitchellAddress Harreds Grace, Md.19. Aug 26 1947 Bertha B. Knight  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1947, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on 19 10 19

Immediate cause of death

DURATION

Asphyxiation  
Due to probably aspirated vomitus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results True

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. H. Ramey M.D.Address Abundant, Md. Date signed 8/26/47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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SEP 18 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

07111

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County HARFORDCity or town Bel Air  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORDCity or town RURAL STREET  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

MARY LOUISE Sidwell

## 3. (b) Social Security Number

4. Sex FE 5. Color or race wh 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife HARVEY P. Sidwell7. Birth date of deceased (mo., day, yr.) MARCH 9, 1923 27 years  
B. (c) If alive, give age8. AGE: Years 24 Months 5 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace NORTH FORK, W. Va.  
(Town, county, and state)10. Usual occupation house wife

## 11. Industry or business

12. Name A. HOBART GRAY beel13. Birthplace Hemlock, N. Carolina14. Maiden name MYRTLE UMBARGER15. Birthplace Chilhowie Va.16. Informant DR. H. P. SidwellAddress Bel Air, Md17. Burial State Bridge Date thereof Aug 27, 1947  
(Burial, cremation, or removal, (month) (day) (year))Cemetery or crematory Delta Pa.Location Delta Pa.18. Funeral director Hubert P. HopkinsAddress Delta Pa.19. 8/22 47 Piscataway  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 19 47 at 11:15 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 19 47 to Aug 22 19 47 and that I last saw her alive on Aug 22 19 47Immediate cause of death Cerebral Hemorrhage DURATIONDue to Chronic Glomerulonephritis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles Richardson Jr. M. D. or other \_\_\_\_\_Address Bel Air, Md Date signed 22 Aug 47



*glomerular*

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AUG 26 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 183

## 1. PLACE OF DEATH:

County HarfordCity or town White Hall R.T.D.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 53

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County HarfordCity or town White Hall R.T.D.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ELIZABETH ANN WILEY SLADE

## 3. (b) Social Security Number

4. Sex Female5. Color or race white6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Anthony Slade7. Birth date of deceased (mo., day, yr.) Oct 14 1971

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 75 Months 9 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Thomas H. Wiley13. Birthplace Harford Co Ind14. Maiden name Rebecca Ann Wiley15. Birthplace Harford Co Ind16. Informant Miss Electa M. SladeAddress White Hall Ind17. Burial Date thereof Aug 1 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BechtelLocation W.T. Hall18. Funeral director Howard S. MacklinAddress White Hall Ind19. Aug 11 1947 Thomas R. Brown  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 1947 to Aug 8 1947and that I last saw her alive on Aug 8 1947

Immediate cause of death

DURATION

Chronic Vascular heartd 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please notefee the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Michael Portner Dr. D.

M. D. or other

Address White Hall Date signed Aug 9 47

RECEIVED

OCT 2 1947

BUREAU # 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH:

County..... Harford  
 City or town..... Cardiff, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 60yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... Maryland County..... Harford  
 City or town..... Cardiff, Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lora H. Snodgrass

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Grover C. Snodgrass  
 6.(c) If alive, give age 64 years  
 7. Birth date of deceased (mo., day, yr.) March 16, 1887  
 8. AGE: Years 60 Months 5 Days 4 If less than one day  
 hrs. min.

9. Birthplace Harford Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business  
 12. Name Thomas W. Heaps  
 13. Birthplace Harford Co. Md.  
 14. Maiden name Rachel Scarborough  
 15. Birthplace Harford Co. Md.  
 16. Informant Grover C. Snodgrass  
 Address Cardiff, Md.

17. Burial Date thereof Aug. 23, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Slate Ridge cemetery  
 Location Delta, Penna.  
 18. Funeral director Hubert P. Harkins  
 Address Delta, Penna.  
 19. Aug. 21, 47 M. G. Kirk  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1947 at 2:15 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Aug 20 1947  
 and that I last saw her alive on Aug 20 1947

Immediate cause of death Cerebral Hemorrhage (Anterior) C-V  
 DURATION 3 days  
 Due to Ant. Sclerotic C-V  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)  
 Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE J. A. G. Hunt M.D.  
 M. D. or other  
 Address Delta Pa. Date signed 8/21/47

RECEIVED

SEP 30 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

## 3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Aug. 28

19 47

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

for 9/2/47

RECEIVED  
AUG 29 1947  
BUREAU V E



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH

County HarfordCity or town Harrods Creek  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 1 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Harrods Creek  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rm. P.P. Camp  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

CECIL ZEIGLER

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elora Zeigler8. (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.)

?1926

8. AGE:

Years

Months

Days

If less than one day

21

hrs. min.

9. Birthplace Sylvania Pa.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Horace Zeigler13. Birthplace Pa.14. Maiden name Elle Brown15. Birthplace Pa.16. Informant Mr. Elora Zeigler (wife)Address Sylvania Pa.17. Burial Date thereof 8/29/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wm. PleasantLocation Sylvania Pa.18. Funeral director Pennington & PenAddress Harrods Creek Md.19. Aug 26 1947 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1947, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death..... DURATION

DROWNING - ACCIDENTAL

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ACCIDENT Date of 8/24/47Where did injury occur? HARRODS CREEK, HARFORD MD  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Swaneshana RiverMeans of injury Slipped off Boat Injured at work? No23. SIGNATURE Jeff Ramsey M.D. M. D. or otherAddress Aberdeen Md Date signed 8/26/47

RECEIVED  
AUG 29 1947  
BUREAU V B

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07116

Reg. Dist. No. 153

### 1. PLACE OF DEATH:

County Harford  
City or town Jarrettville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 47 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Harford  
City or town Jarrettville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) if veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

William Casper Zinkhan

### 3. (b) Social Security Number

—

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Sophia M. Shriver

7. Birth date of deceased (mo., day, yr.) July 6th 1861 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 86 Months 1 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Chersell Germany  
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Retired

12. Name John H. Zinkhan

13. Birthplace Germany

14. Maiden name Elizabeth Decker

15. Birthplace Germany

16. Informant Joseph H. Zinkhan

Address Forest Hill Rd. Md.

17. Burial Date thereof Aug 27 - 47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Wm. Watters Memorial

Location Cortown Harford Co. Md.

18. Funeral director Martin E. Spurtz

Address Jarrettville Md.

19. Aug 27 19 47 Thomas R. Brown  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 19 47 at 4:30 M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 - 47 to August 27 - 47  
and that I last saw him alive on August 27 19 47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Cardiac disease years

Due to Arteriosclerosis yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Valentin Hammeth M. D. or other

Address Baltimore Date signed 8/25/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 2 1947

BUREAU # 8